

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 102793-001

v

US Health and Life Insurance Company
Respondent

Issued and entered
this 27th day of February 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 2, 2009 XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 et seq. After a preliminary review of the material submitted the Commissioner accepted the request on February 9, 2009.

The Commissioner notified US Health and Life Insurance Company (USHL) of the external review and requested the information used in making its adverse determination. The company provided its information on February 5, 2009.

The issue in this matter can be determined by analyzing the contract that defines the Petitioner's health care coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

II FACTUAL BACKGROUND

The Petitioner is a retired City of Detroit police officer. The Petitioner receives health care benefits under a USHL certificate of group insurance (the certificate), a preferred provider organization (PPO) plan. The certificate provides benefits at both network and non-network levels. The non-network benefits come with higher out-of-pocket costs for the Petitioner.

On April 18, 2008, on the advice of his attending physician, the Petitioner was taken by ambulance to XXXXX main Hospital in XXXXX from XXXXX. XXXXX was the ambulance company that provided his transport. XXXXX is not a member of the network. Since XXXXX is not in the PPO network, USHL covered the claim for his transport at the non-network level. The Petitioner appealed, asking USHL to provide coverage at the network level. USHL reviewed the claim but upheld its payment amount.

The Petitioner exhausted USHL's internal grievance process and received its final adverse determination letter dated December 29, 2008.

III ISSUE

Did USHL properly deny coverage at the network level?

IV ANALYSIS

Petitioner's Argument

USHL covered the Petitioner's transport by XXXXX at the non-network level, paying 70% of the eligible expense of \$623.00 and leaving the Petitioner responsible for 30% \$267.06 plus the amount over the usual and customary \$379.30 for a total patient responsibility of \$890.20. USHL would have covered 100% of the eligible expense if XXXXX had been a network provider.

The Petitioner argues that coverage should be provided at the network level because according to his physician he was in an emergency situation and an ambulance was required. He is also asking that the transport be re-billed to reflect an emergency although XXXXX billed as non-emergency. Further, he believes that: XXXXX charges are "way of line" if they are under

contract with XXXXX, and the charges should be considered under the PPOM umbrella.

Respondent's Argument

In its November 5, 2008, final adverse determination letter, USHL said:

According to the schedule of benefits out of network ambulance services is subject to a \$425.00 deductible and payable at 70 percent of usual and customary amount....The payment of the claim was paid appropriately according to the schedule of benefits.

USHL further explained in its February 3, 2009, response to OFIR:

The group insurance coverage provides certain benefits when the employees and dependents receive services from network providers and certain other benefits when they receive services from providers that are not in the network. The benefit amounts payable are based on the network status of the providers. Benefits are not based on the effort of the employees in attempting to obtain services from network providers or on the reasons they do not, such as an emergency. The insured is not required to use the services of any one particular provider. There is no special handling for out-of-network emergencies.

Since XXXXX is not a network provider, USHL says it processed the claim for his services at the non-network level in accordance with the terms of the certificate.

USHL also said that it made an exception in the Petitioner's favor when it processed the claim from Dr. XXXXX because it did not apply any of the eligible expense to the Petitioner's non-network deductible.

Commissioner's Analysis

The certificate's "Schedule of Benefits" describes coverage as follows:

	IN-NETWORK	OUT- OF- NETWORK
Deductible	\$175 per person \$350 per family	\$425 per person \$850 per family
Annual Coinsurance maximum (does not include Deductible or Copays)	\$825 per person \$1650 per family	\$1575 per person \$3150 per family
Copay (Does not apply to Coinsurance maximum)	Per Service. Amount as indicated.	
Lifetime Maximum, All Benefits Combined	\$2,000,000	

	IN-NETWORK (after Deductible unless waived)	OUT-OF-NETWORK (after Deductible)

Ambulance Services	100% of eligible expenses	70% of eligible expenses
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As the “Schedule of Benefits” shows, ambulance service by a non-network provider is subject to the non-network deductible (not applied in this case) and then is covered at 70% of the eligible expense. There is no dispute that XXXXX is a non-network provider. Therefore, USHL in this case appropriately paid 70% of the eligible expense, leaving Petitioner responsible for the 30% coinsurance amount plus the amount above the usual customary in the amount of \$890.20.

USHL’s coverage is based on the network status of the provider. Network level benefits are only available when services are received from network providers. The certificate does not require coverage of any non-network care at the network level, even in an emergency or if there are no network providers available.

The Commissioner finds that USHL correctly covered the Petitioner’s ambulance transport with XXXXX under the terms of the certificate.

**V
ORDER**

The Commissioner upholds US Health and Life Insurance Company’s December 29, 2008, final adverse determination in the Petitioner’s case.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909 -7720.